

# PARENT PERMISSION FORM

## BURNS HIGH SCHOOL HEALTH CENTER (ph) 704-538-3151

Student's Name \_\_\_\_\_

Grade \_\_\_\_\_

Last	First	Middle	Date of Birth	Social Security #
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I understand that Expanded School Health Services are provided in a School Based Health Center at this school by a Nurse Practitioner or Physician Assistant as the result of a contract agreement between the Cleveland County School System and the Cleveland County Health Department. ***I understand that my child may receive these expanded health services only with my written permission.*** Expanded health services include but are not limited to:

- physical assessment
- basic laboratory testing (urinalysis, strep test, hemoglobin, blood sugar, etc.)
- management or diagnosis and treatment of minor conditions
- possible referral for further medical evaluation and follow-up care

I understand that my child will receive General School Health Services *even if I do not give permission for my child to receive expanded health services* as described above. General School Health Services include but are not limited to:

- vision/hearing screening
- health screening for the Exceptional Children's (EC) Program
- emergency care

I understand that minors may give consent for certain confidential health services as permitted by NC General Statute 90-21.5. These services may include: pap smear testing, pregnancy testing, sexually transmitted disease testing, substance abuse and/or mental health services, and referrals and follow-up care related to these confidential services.

I understand that the Nurse Practitioner or Physician Assistant will keep me informed of significant medical findings and treatment recommendations and will encourage my child to communicate with me regarding health needs.

I understand that my child's health records (except for those related to General School Health Services which need to be shared with the school) are the property of Cleveland County Health Department. Information contained in them will be confidential in accordance with state and federal law and accepted medical practice. Copies of the health record will be released only with written consent of the responsible individual (which will be the parent(s) or guardian, unless the student is 18 years of age or where law permits minor consent).

### ★ PLEASE CHECK ONE & SIGN BELOW:

**I GIVE permission** for my child to receive expanded health services as explained above. I understand that I will not be billed personally for the services my child receives, although Insurance and Medicaid will be billed with my authorization. **(Please complete Insurance/Medicaid Information Form and Health History Form included in this packet.)**

I also hereby acknowledge that I have received a copy of the "Notice of Privacy Practices" for the Cleveland County Health Department and understand that I may contact the Cleveland County Health Department if I have questions about the content of the notice.

**I DO NOT GIVE permission** for my child to receive expanded health services.

\_\_\_\_\_  
**Signature of Parent or Legal Guardian**      **Date**      **Telephone #**  
(Please check only one above)

**If I (PARENT or LEGAL GUARDIAN) cannot be reached in an emergency, please CONTACT:**

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
(Relationship to student)

**PLEASE NOTIFY HEALTH CENTER STAFF IF CONTACT INFORMATION CHANGES AT ANY TIME**

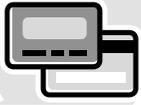
*This parental consent will remain in effect while your child is enrolled at this school, unless you should decide to revoke it, which may be done at any time by notifying Health Center staff.*

**INSURANCE / MEDICAID INFORMATION**  
**EXPANDED SCHOOL HEALTH SERVICES / SCHOOL BASED HEALTH CENTERS**

*Cleveland County Health Department*

**Dear Parent:**

We ask that you provide the information requested below so that the Cleveland County Health Department can bill your student's Medicaid and/or Insurance for School Health Center services provided. **Parents will not be billed for any student services**, and no student will be denied Health Center services based on income, Insurance, or Medicaid status.



*A photocopy of your Insurance or Medicaid card is preferred for accuracy in billing. If this is not possible, please complete the information below.*

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**My Child: (Please check the correct item(s) below)**

\_\_\_\_\_ Is covered under Medicaid / Health Check.....Medicaid Number: \_\_\_\_\_

\_\_\_\_\_ Is covered by NC Health Choice.....Health Choice Number: \_\_\_\_\_

\_\_\_\_\_ Is covered by Insurance ..... (Complete Insurance Information Below)

\_\_\_\_\_ Has an Insurance card for prescription meds

\_\_\_\_\_ Has no Medicaid or Insurance coverage

**\*If student is not covered under Medicaid, are you interested in information on how to apply?**

<b>Full Name of Insurance Company:</b>	<b>Insurance Group # :</b>
<b>Name of Person Listed on Insurance Card (Policy Holder):</b>	<b>Complete Billing Address of Insurance Co.:</b>
<b>Policy Holder's Soc. Sec. #</b> (if student's name is not listed on insurance card):	<b>Telephone # of Insurance Co.:</b>
<b>Policy Holder's Date of Birth</b> (if student's name is not listed on insurance card):	<b>When was this Insurance effective?</b>
<b>Insurance Policy # <u>or</u> Subscriber #:</b>	<b>Employer:</b>

**As Parent/Guardian of the above named student:**

I authorize payment of medical benefits to the Cleveland County Health Department for services rendered, AND I have either attached a copy of my Medicaid/Insurance Card or completed the above information. I confirm that all the information given is complete and accurate.

**Signature:** X \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Parent or Legal Guardian

» **PLEASE NOTIFY HEALTH CENTER OF ANY CHANGES IN THIS INFORMATION** «

**ALL INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL**

